STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185352	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON NURSING CENTER	31 DERICKSON LANE STANTON, KY 40380

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was conducted 08/10/10 through 08/12/10, and a Life Safety Code Survey was conducted 08/10/10. Deficiencies were cited with the highest Scope and Severity of an "E". 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of sixteen (16) sampled residents (Resident #4). The findings include:	F 000 F 280	F280 1.Resident #4 Comprehensive Care Plan was updated to reflect every one hour turning and repositioning schedule on 8/12/2010 by the Director of Nursing. Resident #4 did not experience any change to skin status as of 8/12/2010. 2All residents have the potential to be affected. An audit of all Comprehensive Care Plans will be completed by the Director of Nursing(D.O.N.),RDCS(Regional Director of Clinical Services) and /or the Unit Manager (U.M.)by 9/20/2010 to identify any Comprehensive Care Plan not revised as needed. Any Comprehensive Care Plan not revised and/or not reflective of individual needs will be immediately corrected by 9/21/2010 by RDCS, DON and /or UM. 3.Regional Director of Clinical Services (RDCS) who is Wound Care Certified , to re educate the DON,UM, ETD(Education Training Director) and licensed nurse responsible for skin program management regarding policy and procedure for turning and repositioning schedule, policy and procedure for individualized turning and repositioning schedule and policy and procedure for development and implementation of the individualized Comprehensive Care Plan by 9/15/2010. DON and /or ETD to re educate all nursing personnel regarding policy and procedure for turning and repositioning schedule, policy and procedure for individualized turning and repositioning schedule and policy and procedure for development and implementation of the individualized Comprehensive Care Plan as relates to all plans of care by 9/22/2010.	

RECEIVED
SEP 21 2010
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christy Wilson NHA	Administrator	9/20/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 280	Continued From page 1 1. Observations during a skin assessment on 08/11/10, at 9:30 AM revealed the resident to be lying on the bed and being turned by staff to his/her left side. Further observations at 10:55 AM, 11:53 AM, and 12:45 PM revealed Resident #4 continued to be lying on his/her left side on the bed. Review of Resident #4's medical record revealed an admission date of 05/12/10, and diagnoses of healed Pressure Ulcers to the buttocks, and End-Stage Alzheimer's Dementia. Review of the Quarterly Minimum Data Set (MDS) dated 07/09/10, revealed the resident required extensive assist of two persons for bed mobility and transfers. Further review of the MDS revealed the patient had one (1) Stage II and one (1) Stage IV Pressure Ulcer. Review of the Resident Assessment Protocols Summary (RAPS) dated 05/19/10, revealed Resident #4 triggered for Pressure Ulcers due to he/she required extensive assist with bed mobility, was incontinent of bowel and bladder, and had current pressure ulcers. Review of the Comprehensive Care Plan dated 08/03/10, revealed the resident had a care plan entitled, "Skin Integrity Assessment: Prevention and Treatment Plan of Care". Review of the interventions revealed the resident was to be turned and repositioned. Further review revealed no documented evidence of how often Resident #4 was to be turned and repositioned. Interview on 08/11/10, at 2:18 PM with Certified Nursing Assistants (CNAs) #1 and #2 revealed the resident was on a special turning schedule.	F 280	DON and /or UM to visually audit ten residents to ensure turning and repositioning is occurring per individualized Comprehensive Care Plan and that Comprehensive Care Plan is correct 5x week x 2 weeks, then 3 x week x 2 weeks beginning week of 9/20/2010. RDCS to audit ten(10) entire Comprehensive Care Plans Q month beginning week of 9/20/2010 to ensure POC revised and updated as needed to provide individualized care x 3 months. 4.All audit findings to be presented to Quality Assurance Committee (Administrator, Director of Nursing , Unit Manager, Licensed Nurse responsible for skin program management, Life Enrichment Director, Dietary Services Manager, Medical Director and Social Services Director) for review and revision if needed bi monthly x 2 and then monthly until resolved beginning week of 9/20/2010.QA Committee to review findings of all audits and review corrections made in order to ensure comprehensive care plans are correct and revisions made per resident individual needs. 5.Date of Compliance 9/23/2010	

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F 280	Continued From page 2 The CNAs stated Resident #4 was to be turned every hour. They indicated there was a paper taped to the back of the resident's door that stated the turning schedule. Review of the paper the CNAs showed the surveyor revealed, "Resident to be turned every one hour and PRN (as necessary) side to side in bed". Interview on 08/11/10, at approximately 3:15 PM with the Director of Nursing (DON) revealed if the resident had the special turning schedule on the door to turn every one (1) hour, then this information should have been included on the Comprehensive Care Plan..	F 280	F281 1.Resident #11 physician was notified of leg rests not being on per order by the Director of Nursing(DON) on 8/12/2010. Leg rest was removed immediately per physicians order on 8/12/2010. The Facility Rehab Coordinator(FRC) was immediately re educated regarding physician notification and following physicians orders by the DON on 8/12/2010.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to follow Physician's Orders for one (1) of sixteen (16) sampled residents (Resident #11). The findings include: Review of Resident #11's medical record revealed diagnoses which included status post Left Hip Arthoplasty. Review of the Quarterly Minimum Data Set (MDS) dated 05/17/10, revealed the facility assessed the resident to require extensive assistance with transfers and as being unable to ambulate. Review of the Physician's Orders revealed an order dated 03/01/10, for Resident #11 to have a left elevating leg rest to his/her	F 281	2 All residents have the potential to be affected..DON and /or UM(Unit Manager) and FRC to complete an audit of all physicians orders and compare orders to residents and Comphrehensive Care Plan to identify residents with orders not being followed and /or Comphrehensive Care plan not correct and/or being followed by 9/21/2010. Any resident identified w ith orders that are not being followed and /or Comphrehensive Care Plan is not correct will be immediately reported to the physician, and /or Medical Director and orders implimented and Comphrehensive Care Plan corrected immediately by 9/21/2010. DON/UM and/or ETD to complete a one time audit of physicians orders and C.N.A care plan and Comphrehensive Care Plan to identify any resident who does not have correct order reflected on plan of care by 9/22/2010.Any resident identified who has a plan of care that does not match physicians orders will be immediately corrected, staff will be re educated immediately and plan of care updated by the DON/UM and /or UM by 9/22/2010.	

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F 281	Continued From page 3 wheelchair. Observation on 08/11/10, at 5:50 PM and 08/12/10, at 8:35 AM, 9:45 AM, 11:50 AM, and 12:30 PM revealed Resident #11 to be sitting up in a wheelchair with no legs rests. Interview on 08/12/10, at 11:55 AM with Certified Nursing Assistant (CNA) #2, who was caring for Resident #11 that day, revealed the CNA Care Plan indicated the resident was to have an elevating left leg rest on his/her wheelchair. Interview on 08/12/10, at 12:07 PM with the Therapy Manager revealed according to the Physician's Order the resident should have an elevating left leg rest on his/her wheelchair. She stated however, Resident #11 had improved and no longer needed the left elevating leg rest on his/her wheelchair. The Therapy Manager stated there must have been an oversight on Therapy's part in regards to having the Physician discontinue the left leg rest. Interview on 08/12/10, at approximately 3:37 PM with the Director of Nursing (DON) revealed according to the Physician's Order the resident should have had an elevating left leg rest on his/her wheelchair. She stated if Resident #11 had improved an order should have been obtained to discontinue the left leg rest.	F 281	3.DON and /or UM and FRC to visually audit 15 residents to ensure physicians orders are correct and reflected on C.N.A care plan and Comphrehensive Care plan and that Comphrehensive Plan of Care is being followed 2 x week x 2 weeks, then 1 x week x 4 weeks beginning week of 9/20/2010. DON and /or UM to complete an audit of 10 C.N.A. care plans and Comprehensive Care Plans to ensure care is being provided per physicians orders and that staff are aware and following orders weekly x 4 weeks then bi monthly x one month beginning week of 9/20/2010. DON to re educate Education Training Director (ETD) and FRC regarding policy and procedure for following physicians orders by 9/20/2010. ETD and /or UM to re educate all nursing and therapy personnel regarding following policy and procedure for following physicians order by 9/20/2010. ETD/DON to re educate all nursing staff to follow C.N A plan of care and Comphrehensive Care Plan and that this is reflective of physicians orders by 9/21/2010. RDCS to randomly audit 10 Comphrehensive Care Plans and compare to physicians orders to ensure orders are correct , being followed and that Comphrehensive Care Plan is correct and being followed , 1 x monthly beginning week of 9/20/2010 x 2 months.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282	4.All audit findings to be presented to the Quality Assurance Committee for review and revision if needed bi monthly x 2 months then monthly beginning week of 9/20/2010.DON to present audit findings and visual audit findings and team to make reccomenndations to ensure physicians orders are correct and being followed and Comphrehensive Care Plan is correct and being followed bi monthly x 2 monthly then monthly beginning week of 9/20/2010. 5.Date of Compliance 9/23/2010	

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F 282	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure care was provided in accordance with the Comprehensive Care Plan for one (1) of sixteen (16) sampled residents (Resident #11). The findings include: Review of Resident #11's medical record revealed diagnoses which included status post Left Hip Arthoplasty. Review of the Quarterly Minimum Data Set (MDS) dated 05/17/10, revealed the facility assessed the resident to require extensive assistance with transfers and as being unable to ambulate. Review of Resident #11's Comprehensive Care Plan, dated 08/10/10, revealed a "Fall/Injury Assessment: Prevention and Management Plan of Care" that indicated the resident was to have a left elevating leg rest on his/her wheelchair. Observations on 08/11/10, at 5:50 PM and 08/12/10, at 8:35 AM, 9:45 AM, 11:50 AM, and 12:30 PM revealed Resident #11 to be sitting up in a wheelchair with no legs rests. Interview on 08/12/10, at 12:03 PM with Registered Nurse #4 revealed the Comprehensive Care Plan stated Resident #11 was to have a left elevating leg rest on his/her wheelchair. RN #4 further stated the left leg rest should have been on the resident's wheelchair. Interview on 08/12/10, at 12:07 PM with the Therapy Manager revealed the Comprehensive Care Plan indicated Resident #11 should have an	F 282	F282 1.Resident #11 physician was notified of leg rests not being on per order by the Director of Nursing(DON) on 8/12/2010. Leg rest was removed immediately per physicians order on 8/12/2010. The Facility Rehab Coordinator(FRC) was immediately re educated regarding physician notification, following physicians orders and following the Comprehensive Plan of care by the DON on 8/12/2010. Resident #11 Comprehensive Plan of Care was updated by DON on 8/13/2010. 2 All residents have the potential to be affected. DON and /or UM(Unit Manager)/ETD and FRC to complete an audit of all Comprehensive Care Plans to identify residents who has a Comprehensive Care plan that is not correct and/or being followed by 9/21/2010. Any resident who has a Comprehensive Care Plan that is not correct will be immediately reported to the physician, and /or Medical Director and orders implemented and Comprehensive Care Plan corrected immediately by 9/21/2010 by the DON,UM and/or ETD. DON/UM and/or ETD to complete a one time audit of physicians orders and C.N.A care plan and Comprehensive Care Plan to identify any resident who does not have correct order reflected on plan of care by 9/22/2010.Any resident identified who has a plan of care that does not match physicians orders will be immediately corrected, staff will be re educated immediately and plan of care updated by the DON/UM and /or UM by 9/22/2010. 3.DON and /or UM and FRC to visually audit 15 residents to ensure physicians orders are correct and reflected on C.N.A care plan and Comprehensive Care plan and that Comprehensive Plan of Care is being followed 2 x week x 2 weeks, then 1 x week x 4 weeks beginning week of 9/20/2010.	

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F 282	Continued From page 5 elevating left leg rest on his/her wheelchair. According to the Therapy Manager, the resident no longer needed the leg rest as his/her condition had improved. Interview on 08/12/10, at approximately 3:37 PM with the Director of Nursing (DON) revealed the Comprehensive Care Plan indicated Resident #11 should have an elevating left leg rest on his/her wheelchair. The DON further stated the resident should have a left leg rest on his/her wheelchair. She stated if Resident #11 had improved the Comprehensive Care Plan should have been revised to include this information.	F 282	Charge nurse to audit 2 residents Comprehensive Care Plans, compare to C.NA care plan and ensure plan of care is correct and being followed 5 x week x 2 weeks then 2 x week x 2 weeks beginning week of 9/20/2010. ETD and /or UM to re educate all nursing and therapy personnel regarding implementing, revising and following Comprehensive Plan of Care by 9/20/2010. ETD/DON to re educate all nursing staff to follow C.N A plan of care and Comprehensive Care Plan and that this is reflective of physicians orders by 9/21/2010. RDCS to randomly audit 10 Comprehensive Care Plans and compare to physicians orders to ensure orders are correct , being followed and that Comprehensive Care Plan is correct and being followed , 1 x monthly beginning week of 9/20/2010 x 2 months. 4.All audit findings to be presented to the Quality Assurance Committee for review and revision if needed bi monthly x 2 months then monthly beginning week of 9/20/2010.DON to present audit findings and visual audit findings and team to make recommendations to ensure physicians orders are correct and being followed and Comprehensive Care Plan is correct and being followed bi monthly x 2 monthly then monthly beginning week of 9/20/2010. 5.Date of Compliance 9/23/2010	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being for one (1) of sixteen (16) sampled residents (Resident #5). The wound nurse's assessment of Resident #5's skin revealed an open area on the resident's right shin, which was covered with a Band-Aid. This area was not documented in the required section	F 309		

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F 309	Continued From page 6 of the resident's clinical record, the Treatment Administration Record. The findings include: Review of Resident #5's medical record revealed the resident was admitted on 04/29/02, with diagnoses which included Coronary Artery Disease, End Stage Renal Disease, Diabetes, and Dementia. Review of the facility's Policy and Procedure on Weekly Skin Assessment revealed this assessment included a head to toe visualization of the residents' skin, with documentation of the location, type, and size of any skin impairment on the Treatment Administration Record (TAR). Further review of this policy revealed the area of skin impairment was to be monitored daily until healed, using the TAR to chart the area's treatment and progress. Observation on 08/11/10, at 2:50 PM of the head to toe skin assessment performed by Licensed Practical Nurse (LPN) #3 (who is also the facility's Wound Care Nurse) revealed an open area with the measurements of 0.6 x 0.8 x 0.1 centimeters on Resident #5's right shin that was covered with a Band-Aid. Review of Resident #5's TAR revealed no documented evidence of the open area on the resident's right shin. Review of the Comprehensive Care Plan revealed no documented evidence of the open area on the Skin Integrity Care Plan. Review of the Nurse's Progress Notes revealed no documented evidence of the area or of notification of the physician or family of the open area. Review of	F 309	F309 1.Resident #5 physician was notified of open area on Right shin by L.P.N. on 8/12/2010 and treatment orders were obtained and implemented. A 100% skin audit was completed on Resident #5 and no other areas identified on 8/12/2010 by the treatment nurse. 2.A one time 100% skin audit will be completed by the DON,UM, ETD and Licensed nurse responsible for management of the skin program to identify any skin impairment not previously identified by 9/20/2010. A one time audit of the Treatment Administration record will be completed by the DON and UM to identify any known area on resident without treatment orders by 9/20/2010. Any open area and /or change in skin status idntified the DON/UM to identify when last skin assessment was completed,by whom, date and re educate nurse if skin assessment compited less than 48 hours prior by 9/20/2010. Any change in skin status noted on TAR without order or physician notification , the nurse will be re educated by the DON/UM and/or ETD immediately by 9/20/2010. 3.DON and /or ETD to re educate all Licensed Nurses regarding skin policy , that includes intervention , identification of and treatment of any open area and reporting any change in condition by 9/20/2010. ETD to re educate all C.N.A's regarding policy for reporting any change in condition, and skin policy, which includes prevention, intervention , treatment and management of any open area by 9/20/2010.	

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F 309	Continued From page 7 the Physician's Orders revealed no documentation of treatment orders for the open area to Resident #5's right shin. Interview on 08/11/10, at 3:00 PM with LPN #3 (Wound Care Nurse) revealed this was a new skin lesion on Resident #5's shin. Further interview revealed the nurse was unable to find any documentation of this area, including notification of the Physician and resident's family. LPN #3 indicated the correct procedure for dealing with resident skin impairments (assessment, documentation and procurement of a physician treatment order) was not done. On 08/11/10, at 3:10 PM interview with Registered Nurse (RN) #1, the Unit Manager where Resident #5 resides, revealed facility policies and procedures were not followed for this resident in regards to the open area on his/her right shin. She stated the open area should have been recorded on the resident's TAR, the Comprehensive Care Plan should have been updated with the information and the Physician should have been notified for treatment orders.	F 309	DON and /or UM/ETD to complete 10 random skin audits weekly x 4 weeks then 5 random skin audits to be completed weekly x 2 weeks to ensure skin program policy and procedure is being followed and no skin impairment is present not previously identified beginning week of 9/20/2010. DON and /or UM to audit treatment administration record 1 x weekly x 4 weeks, then bi monthly x 2 to ensure any identified skin impairment and treatment is documented per skin policy and procedure beginning week of 9/20/2010. DON/UM and/or ETD to audit 5 records to review nurses notes to identify any change condition to ensure policy followed for physician and family notification beginning week of 9/20/2010. 4.All audit findings to be presented to Quality Assurance Committee for review and revision of plan if needed bi monthly x 2 then 1 x monthly beginning week of 9/20/2010. DON to present audit findings to QA Committee and review any open areas found for trending and tracking beginning week of 9/20/2010. 5.Date of Compliance 9/23/2010.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	F314 1.Resident #4 Comprehensive Care Plan was updated to reflect every one hour turning and repositioning schedule on 8/12/2010 by the Director of Nursing. Resident #4 experienced no change to skin status as of 8/13/2010. Resident #4 physician was notified of times resident was turned and schedule per plan of care on 8/13/2010.	

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F 314	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure one (1) of sixteen (16) sampled residents (Resident #4) received the necessary treatment and services to promote healing and prevent new pressure ulcers from developing. The findings include: Review of Resident #4's medical record revealed the resident had a history of healed Stage IV Pressure Ulcer to the right buttock, and had current Stage II Pressure Ulcers to his/her right inner elbow and coccyx. Review of the Quarterly Minimum Data Set (MDS) dated 07/09/10, revealed the resident required extensive assist of two persons for bed mobility and transfers. Further review of the MDS revealed the patient had current Pressure Ulcers. Review of the Resident Assessment Protocols Summary (RAPS) dated 05/19/10, revealed Resident #4 triggered for Pressure Ulcers due to he/she required extensive assist with bed mobility, was incontinent of bowel and bladder, and had current pressure ulcers. Review of the Comprehensive Care Plan dated 08/03/10, revealed the resident had a care plan for the treatment and prevention of Pressure Ulcers. The interventions included to turn and reposition the resident, with no frequency indicated. Observations on 08/11/10, revealed the resident to be lying on his/her bed. Continued observation revealed staff turned Resident #4 to his/her left	F 314	2All residents have the potential to be affected. An audit of all Comprehensive Care Plans will be completed by the Director of Nursing(D.O.N.),RDCS(Regional Director of Clinical Services) and /or the Unit Manager (U.M.)by 9/20/2010 to identify any Comprehensive Care Plan not revised as needed Any Comprehensive Care Plan not revised and/or not reflective of individual needs will be immediately corrected by 9/21/2010 by RDCS, DON and /or UM. A 100% skin audit of all residents will be completed by DON,UM, Treatment Nurse and ETD(Education Training Director) to identify any area of skin impairment, any area found will be immediately reported to the phsycian , family and treatment obtained per policy, this will be completed by 9/18/2010. A one time visual audit of all residents on both shifts who require turning and repositioning will be conducted by DON , ETD and /or UM to identify any resident not turned per individual schedule, any resident not turned and repositioned per individual schedule will be immediately turned and repositioned , one on one education conducted immediately with identified residents nurse and C.N A and physician will be notified, this will be completed by 9/21/2010. 3.Regional Director of Clinical Services (RDCS) who is Wound Care Certified , to re educate the DON,UM, ETD(Education Training Director) and licensed nurse responsible for skin program management regarding policy and procedure for turning and repositioning schedule, policy and procedure for individualized turning and repositioning schedule, policy for prevention and healing of pressure ulcers and policy and procedure for development and implementation of the individualized Comprehensive Care Plan by 9/15/2010. All newly hired nursing employees will receive education regarding policy for wound prevention, turning and repositioning, following individual plan of care per Comphrehensive plan of care, and completing turning and repositioning rounds in orientation beginning week of 9/20/2010	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185352	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON NURSING CENTER	31 DERICKSON LANE STANTON, KY 40380

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F 314	Continued From page 9 side at 9:30 AM. Further observations at 10:55 AM, 11:53 AM, and 12:45 PM revealed Resident #4 continued to be lying on his/her left side on the bed. Interview on 08/11/10, at 2:18 PM with Certified Nursing Assistants (CNAs) #1 and #2 revealed there was a yellow dot with a black line through it on the outside of the resident's room. According to the CNAs, this indicated the resident was on a special turning schedule. The CNAs stated there was a paper taped to the back of the resident's door that informed them of the special turning schedule. Review of the paper the CNAs showed the surveyor revealed Resident #4 was to be turned side to side every one hour and PRN (as necessary). Further interview with the CNAs revealed they had "tried to turn" the resident "every hour". However, they indicated the Wound Care Nurse and another staff member had turned the resident also that morning. Interview on 08/11/10, at 2:55 PM with the Wound Care Nurse revealed she had only assisted turning the resident at 9:30 AM. She stated the CNAs were to turn Resident #4 every hour due to his/her fragile skin. Interview on 08/11/10, at approximately 3:15 PM with the Director of Nursing (DON) revealed if the resident had the special turning schedule on the door to turn every hour, then he/she should have been turned every one hour. She further stated this information should have been included on the Comprehensive Care Plan.	F 314	DON and /or ETD to re educate all nursing personnel regarding policy and procedure for turning and repositioning schedule, policy and procedure for individualized turning and repositioning schedule, policy for prevention and healing of pressure ulcers and policy and procedure for development and implementation of the individualized Comprehensive Care Plan as relates to all plans of care by 9/21/2010. DON and /or UM to visually audit ten residents to ensure turning and repositioning is occurring per individualized Comprehensive Care Plan and that entire Comprehensive Care Plan is correct and being followed 5x week x 2 weeks, then 3 x week x 2 weeks beginning week of 9/20/2010. RDCS to audit ten(10) entire Comprehensive Care Plans Q month beginning week of 9/20/2010 to ensure POC revised and updated as needed and that care is being provided per individual plan of care x 3 months. 4 DON to present all audit findings to Quality Assurance Committee (Administrator, Director of Nursing , Unit Manager, Licensed Nurse responsible for skin program management, Life Enrichment Director, Dietary Services Manager, Medical Director and Social Services Director) for review and revision if needed bi monthly x 2 and then monthly until resolved beginning week of 9/20/2010.QA Committee to review findings of all audits and review corrections made in order to ensure comprehensive care plans are correct and that prevention of skin impairment policy is followed and revisions made per resident individual needs. QA Committee to review all residents with pressure areas and review plan of care and revise plan as needed based on review findings bi monthly x 2 then monthly beginning week of 9/20/2010. 5.Date of Compliance 9/23/2010	
F 501 SS=D	483.75(l) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve	F 501		

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F 501	Continued From page 10 as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have a system in place to ensure the Medical Director's involvement in the implementation of resident care policies and the coordination of medical care in the facility. The findings include: Interview on 08/12/10, at 2:30 PM with the Regional Director of Operations revealed the facility had a new Medical Director that started 06/19/10. She stated the previous Medical Director had not attended Quality Assurance Committee meetings since the last survey in 05/09. Therefore the former Medical Director was not involved in the implementation of facility policies and procedures, and did not ensure the coordination of medical care in the facility. Interview on 08/12/10, at 4:15 PM with Medical Director #1, the former Medical Director, revealed the facility had several Administrators in the past year. He stated he was not informed of the Quality Assurance Committee meetings. According to Medical Director #1 prior to this he had attended regularly and gave input to the facility regarding identified concerns. Medical Director #1 stated he gave the facility days he was available to come to the Quality Assurance	F 501	F501 1.Medical Director was made aware of Quality Assurance Committee Minutes and approved them for month of August 2010 by the Administrator on 9/01/2010. A Quality Assurance Meeting will be held by 9/20/2010 and the Medical Director is scheduled to attend. 2.RDCS (Regional Director of Clinical Services) and /or RDO(Regional Director of Operations) to attend the September Quality Assurance Committee Meeting to identify barriers to the Medical Director attending meetings per policy and procedure and ensure team members understand importance of Medical Director oversight. 3.RDO to re educate Administrator regarding policy and procedure for Quality Assurance meetings and Medical Director oversight by 9/01/2010. Administrator to re educate Quality Assurance team members regarding policy and procedure for Quality Assurance Meetings and Medical Director oversight by 9/5/2010. Administrator to notify Medical Director in writing of the policy and procedure for attending and participating in Quality Assurance program by 9/05/2010. Administrator to notify Medical Director in writing of scheduled Quality Assurance Meetings at least 21 days in advance beginning October 2010 meeting. RDO and /or RDCS to attend Quality Assurance Meetings for 2 months beginning month of September.	

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F 501	Continued From page 11 Committee meetings, however he was not notified when the meetings occurred. He stated he had "patients" there he saw, however over the past year he had not given input into the coordination of medical care. He further stated he had not participated in the development and implementation of policies and procedures during the past year.	F 501	4.Quality Assurance team to monitor Medical Director attendance and revise plan as needed monthly beginning month of September 2010. 5.Date of Compliance 9/22/2010.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain clinical records for one (1) of sixteen (16) sampled residents (Resident #10) in accordance with the facility's written policies and procedures related to post fall/injury documentation. The findings include: Review of the facility's "Fall/Injury Management-Post Fall or Injury" Policy/Procedure dated 01/09,	F 514	F514 1.Resident # 10 did not experience any change of condition following the falls on 6/29/2010, 7/03/2010 and 7/7/2010. Medical Director was notified of follow up fall documentation not being completed per policy regarding Resident#10 on 9/16/2010. 2 DONor UM to audit all falls for 72 hours following a fall beginning 9/02/2010 thru 9/22/2010 to identify if licensed nurses are following policy and procedure for assessment and follow up documentation after a fall. Any licensed nurse identified as not following fall policy and procedure for follow up assessment and documentation after a fall will be immediately re educated by the DON or the UM. Medical Records to ensure all completed assessments are filed in clinical record as per policy by 9/16/2010. All residents have the potential to be affected and IDT (Interdisciplinary Team) to review all falls x 4 weeks to ensure appropriate assessment is completed and documented as part of the clinical record to identify any resident at risk beginning week of 9/15/2010.	

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F 514	Continued From page 12 revealed the facility would continue documentation for seventy-two (72) hours on each shift after a resident experienced a fall or injury. Review of Resident #10's record revealed the resident experienced a fall on 06/29/10, at 4:45 PM. However, there was no documented evidence the facility implemented their policy, related to falls on 07/01/10 and 07/02/10. Also, there was no evidence the facility followed their policy during the 7:00 AM to 7:00 PM shift on 07/03/10. Record review revealed Resident #10 experienced two (2) falls on 07/03/10, one (1) at 5:00 PM and another at 9:00 PM. However, there was no documented evidence of the required fall follow-up documentation on the 7:00 PM to 7:00 AM shift on 07/03/10, or on the 7:00 AM to 7:00 PM shift on 07/04/10. Further review of the record revealed the resident experienced another fall on 07/07/10, at 6:00 PM. Review of the record revealed no documented evidence of the follow-up to this fall on the 7:00 PM to 7:00 AM shift on 07/07/10, or the 7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM shifts on 07/08/10. Interview on 08/12/10, at 11:20 AM with Licensed Practical Nurse #7, the Unit Manager on which the resident resided, revealed when a resident experienced a fall, nurses were to perform follow-up documentation on the residents condition for seventy-two (72) hours after the fall. Interview on 08/12/10, at 2:50 PM with the Administrator and Director of Nursing (DON)	F 514	3.DON and /or ETD to re educate all licensed nurses regarding fall policy and documentation after a fall by 9/9/2010. DON and/or UM to audit all falls for 72 hours following a fall to ensure licensed nurses are following fall policy and procedure for assessment and follow up documentation beginning 9/2/2010 thru 9/22/2010, then 50% of falls will be audited x 2 weeks beginning week of 9/22/2010. ETD to re educate nursing staff regarding fall risk, policy and procedure for follow up after a fall and maintaining clinical records per policy by 9/20/2010. 4.All audit finding to be presented to Quality Assurance team for review and revision if needed bi monthly x 2 then monthly beginning week of 9/22/2010.DON to present any re education and follow up in scheduled QA meetings beginning week of 9/20/2010. 5.Date of Compliance 9/23/2010.	

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F 514	Continued From page 13 revealed there should be documentation on each shift (7:00 AM to 7:00 PM and 7:00 PM to 7:00 AM) for seventy-two (72) hours after a resident experiences a fall. Further interview revealed the required seventy-two (72) hours of follow-up documentation after Resident #10's falls on 06/29/10, 07/03/10, and 07/07/10 should have been completed as per facility policy.	F 514		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 520	F520 1.Medical Director was made aware of Quality Assurance Committee Minutes and approved them for month of August 2010 by the Administrator on 9/01/2010. A Quality Assurance Meeting will be held by 9/20/2010 and the Medical Director is scheduled to attend. 2.RDCS (Regional Director of Clinical Services) and /or RDO(Regional Director of Operations) to attend the September Quality Assurance Committee Meeting to identify barriers to the Medical Director attending meetings per policy and procedure and ensure team members understand importance of Medical Director oversight.	

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F 520	Continued From page 14 Based on interview and record review it was determined the facility failed to ensure the Medical Director participated in the Quality Assurance Committee meetings. The findings include: Review of the facility's Quality Assurance (QA) Committee quarterly meeting sign-in forms from 05/09 through 05/10, revealed no documented evidence of the Medical Director's signature. Interview on 08/12/10, at 2:30 PM with the Regional Director of Operations revealed the Medical Director was the physician designated by the facility to participate in the QA Committee meetings. She stated the facility had a new Medical Director that was appointed in 06/10, and who now attended the QA Committee meetings. In addition, she stated the former Medical Director (Medical Director #1) did not attend and participate in the QA Committee meetings. According to the Regional Director of Operations, the former Medical Director was telephoned and informed of the meetings, however he did not come to the meetings. She indicated therefore he was unable to participate in developing and implementing appropriate plans of action to correct identified quality deficiencies. Interview on 08/12/10, at 4:15 PM with Medical Director #1 (the former Medical Director) revealed he had not participated in the facility's QA Committee meetings for approximately a year. He stated there had been changes in the Administrators during that period of time and he was not notified to come to the QA Committee meetings.	F 520	3.RDO to re educate Administrator regarding policy and procedure for Quality Assurance meetings and Medical Director oversight by 9/01/2010. Administrator to re educate Quality Assurance team members regarding policy and procedure for Quality Assurance Meetings and Medical Director oversight by 9/5/2010. Administrator to notify Medical Director in writing of the policy and procedure for attending and participating in Quality Assurance program by 9/05/2010. Administrator to notify Medical Director in writing of scheduled Quality Assurance Meetings at least 21 days in advance beginning October 2010 meeting. RDO and /or RDCS to attend Quality Assurance Meetings for 2 months beginning month of September. 4.Quality Assurance team to monitor Medical Director attendance and revise plan as needed monthly beginning month of September 2010. 5.Date of Compliance 9/22/2010.	

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/10/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "E".	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure approved access doors were used in smoke barriers according to NFPA standards. This deficient practice affected (1) smoke compartment and (21) residents. The findings include: Observation on 08/10/2010 at 11:24 AM, revealed the smoke barrier in the center hall above room 215 had an unapproved access door. The observation was confirmed with the Maintenance Director.	K 025	K 025 The smoke barrier in the center hall above room 215 will be replaced by 9/24/2010. Replacing the door will ensure approved access doors are used in smoke barriers per NFPA standards.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Denise Burgess, RN DON	DON	09/01/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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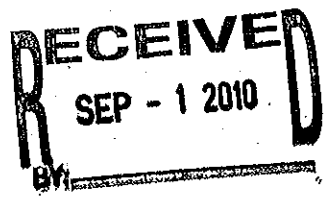
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 08/10/2010. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "E".	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure approved access doors were used in smoke barriers according to NFPA standards. This deficient practice affected (1) smoke compartment and (21) residents. The findings include: Observation on 08/10/2010 at 11:24 AM, revealed the smoke barrier in the center hall above room 215 had an unapproved access door. The observation was confirmed with the Maintenance Director.	K 025	K 025 The smoke barrier in the center hall above room 215 will be replaced by 9/24/2010. Replacing the door will ensure approved access doors are used in smoke barriers per NFPA standards.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 Interview on 08/10/2010 at 11:24 AM, with the Maintenance Director, revealed that during the last survey the facility had been cited for access doors in the smoke barriers and he had replaced all access doors in the smoke barriers. Further interview revealed the Maintenance Director had mistakenly placed the approved access door in the wrong area. Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2:* Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air condi-tioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.	K 025		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on interview and record review it was	K 069	K 069 The kitchen range hood system will be inspected by 9/15/2010. The inspections will be scheduled every 6 months to comply with NFPA standards.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185352	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/10/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANTON NURSING CENTER	31 DERICKSON LANE STANTON, KY 40380

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	Continued From page 2 determined, the facility failed to ensure the kitchen hood fire suppression system was inspected according to NFPA standards. The findings include: During the Life Safety Code tour on 08/10/2010 at 11:50 PM,with the Director of Maintenance, record review revealed no documented evidence the facility's kitchen range hood system was being inspected semi-annually as required. The last documented inspection occurred on 04/03/2009. The kitchen range hood systems must be inspected semi-annually to ensure they function properly in the event of a fire. Interview on 08/10/2010 at 11:50 PM, with the Maintenance Director, revealed he was unaware of the hood needing the inspection semi-annually. Reference: NFPA 96 (1998 edition) 8-2* Inspection. An inspection and servicing of the fire extinguishing system and listed exhaust hoods containing a constant or fire-actuated water system shall be made at least every 6 months by properly trained and qualified persons.	K 069		